GREGORY J. SMITH
SAN DIEGO COUNTY ASSESSOR/RECORDER/CLERK
1600 PACIFIC HIGHWAY, ROOM 103
SAN DIEGO, CALIFORNIA 92101-2480
TELEPHONE (619) 531-5763

For additional information and/or claim forms:
Internet: http: www.sdarcc.com

2004 WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT REHABILITATION - LIVING QUARTERS (Yearly Filing)

A separate affidavit must be filed for each location.

This affidavit is required under the provisions of sections 251 and 254.5 of the Revenue and Taxation Code for those organizations where the use of the property involves rehabilitation of persons and/or living quarters.

The affidavit must accompany the claim for Welfare Exemption and be filed with the Assessor, by **February 15. If you do not complete and file this form, your exemption may be denied.**

_____ states:
(Name of person making affidavit)

1. He/She is _____
(Title such as president, etc.)
2. of the _____,
(Corporate or organization name)
3. the address of which is _____;
(Complete mailing address including zip code)
4. for the property located at _____;
(Address of property including zip code)
5. that he or she makes this affidavit on behalf of this organization in support of a claim for exemption for the **2004 – 2005** fiscal year.

CERTIFICATION

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing and all information hereon, including any accompanying statements or documents, is true, correct, and complete to the best of my knowledge and belief.

SIGNATURE OF PERSON MAKING AFFIDAVIT	*DATE*

HOUSING - LIVING QUARTERS

(This section is to be completed if one or more persons live on the premises)

A. Total number of persons who were housed on the premises the last night in December (*include persons who may be temporarily away):*

1. Number of persons being rehabilitated . . . . . _____
2. Number of unoccupied beds available for persons to be rehabilitated . . . . . _____
3. Number of staff members necessary to care for those persons being rehabilitated. *(Attach a list which describes the job performed and the number of persons involved.)* . . . . . _____
4. Number of other staff members . . . . . _____
5. Number of other persons who are not directly connected with the rehabilitation program . . . . . _____

B. Length of stay of persons being rehabilitated who were housed on the premises the last night in December:

1. Number of persons
   Less than six months . . . . . _____
   6 months - 1 year . . . . . _____
   1 year - 2 years . . . . . _____
   2 years or longer (list by number of years) . . . . . _____
2. **Total** *(this figure **must** agree with the total given above for persons being rehabilitated):*. . . . . _____

C. Do persons being rehabilitated pay, donate, or perform fund producing work for their room and/or board?. . . . . ☐ **YES** ☐ **NO**

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.

_____

_____

_____

D. Do staff members who care for those being rehabilitated pay, donate, or perform work for their room and/or board (in lieu of, or from their salary)? . . . . . ☐ **YES** ☐ **NO**

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.

_____

_____

_____

E. Do other staff members pay, donate, or perform work for their room and/or board (In lieu of, or from their salary)? . . . . . ☐ **YES** ☐ **NO**

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.

_____

_____

_____

F. Do the other persons not directly connected with the rehabilitation program pay, donate, or perform work for their room and/or board? . . . . . ☐ **YES** ☐ **NO**

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.

_____

_____

_____

REHABILITATION

A. On a separate sheet describe your rehabilitation program and activities in detail.

B. Thrift shop, workshop, manufacturing, or similar activities.

Number of hours per week the store or other facility is operated: _____

Total number of persons employed on the premises on January 1:

1. Persons being rehabilitated
   a. Full-time _____
   b. Part-time _____
   c. Length of employment of persons being rehabilitated:
      Number of persons, less than six months _____
      Number of persons, 6 months - 1 year _____
      Number of persons, 1 year - 2 years _____
      Number of persons, longer than 2 years _____
      (list by number of years)
2. Staff and/or others
   a. Full-time _____
   b. Part-time _____

C. Total number employed off the premises, but in the operations of the store or other facility as of January 1:

1. Persons being rehabilitated
   a. Full-time _____
   b. Part-time _____
   c. Length of employment of persons being rehabilitated:
      Number of persons, less than six months _____
      Number of persons, 6 months - 1 year _____
      Number of persons, 1 year - 2 years _____
      Number of persons, longer than 2 years _____
      (list by number of years)
2. Staff and/or others
   a. Full-time _____
   b. Part-time _____

D. Total number of hours worked during the time period included in the financial statements that accompany the claim:

1. Persons being rehabilitated
   a. Number of hours worked _____
   b. Number of persons involved _____
2. Staff and/or others
   a. Number of hours worked _____
   b. Number of persons involved _____

E. Salaries and wages paid during the time period included in the financial statements that accompany the claim:

1. Persons being rehabilitated
   a. Salaries and Wages _____
   b. Number of persons involved _____
2. Staff and/or others
   a. Salaries and Wages _____
   b. Number of persons involved _____

F. Does a person, management firm, or entity other than the organization filing this claim operate the store or facility? . . . . . ☐ **YES** ☐ **NO**

If **yes**, please provide the operators name and mailing address:

_____

_____

_____

Amount of salary or fee *(attach a copy of the contract or other document that indicates the basis for the salary or fee)*:. . . . . $ _____

G. Is housing for persons being rehabilitated and/or living quarters for staff provided? . . . . . ☐ **YES** ☐ **NO**

If **yes**, explain the necessity and complete the section titled Housing - Living Quarters.